

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E376		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 08/21/2012	
NAME OF PROVIDER OR SUPPLIER  TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 305 E NORTH ST BOONVILLE, IN 47601			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
K0000	<p>A Quality Assurance Walk-thru Survey was conducted by the Indiana State Department of Health.</p> <p>Survey Date: 08/21/12</p> <p>Facility Number: 000450 Provider Number: 15E376 AIM Number: 100273890</p> <p>Surveyor: Lex Brashear, Life Safety Code Specialist</p> <p>At this Quality Assurance Walk thru survey, Transcendent Healthcare of Booneville – North, LLC was found not in compliance with 410 IAC 16.2–3.1–19(ff).</p> <p>This one story facility was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. Resident rooms were not provided with smoke detectors. The facility has a capacity of 50 and had a census of 37 at the time of this</p>		K0000				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/01/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E376		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 08/21/2012	
NAME OF PROVIDER OR SUPPLIER  TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 305 E NORTH ST BOONVILLE, IN 47601			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	<p>survey.</p> <p>The facility was found in compliance with state law in regard to sprinkler coverage, however, the facility was not in compliance with state law in regard to smoke detector coverage.</p> <p>All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/23/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E376		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 08/21/2012	
NAME OF PROVIDER OR SUPPLIER  TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 305 E NORTH ST BOONVILLE, IN 47601			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
K9999	<p>State Findings</p> <p>3.1-19 ENVIRONMENT AND PHYSICAL STANDARDS</p> <p>3.1-19(ff) A health facility licensed under 16-28 and this rule must do the following: (1) Have an automatic sprinkler system installed throughout the facility before July 1, 2012. (2) If an automatic sprinkler system is not installed throughout the health care facility before July 1, 2010, submit before July 1, 2010 a plan to the department for completing the installation of the automatic sprinkler system before July 1, 2012. (3) Have a battery operated or hard-wired smoke detector in each resident's room before July 1, 2012.</p> <p>This State Rule has not been met as evidenced by: Based on record review, observation, and interview; the facility failed to install smoke detectors in each resident's room before July 1, 2012. This</p>		K9999	<p>Transcendent Healthcare of Boonville-North, LLC Life Safety POC 2012</p> <p>By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective August 31, 2012 to the Life Safety Code Recertification Survey conducted on August 7, 2012</p> <p>K9999</p> <p>It is the practice of Transcendent Healthcare of Boonville-North, LLC to assure that the regulations related to Life Safety Code 3.1-19 Environment and Physical Standards are in compliance.</p> <p><i>The correction action taken for those residents found to be affected by the deficient practice include:</i></p>		08/31/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E376		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 08/21/2012	
NAME OF PROVIDER OR SUPPLIER  TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 305 E NORTH ST BOONVILLE, IN 47601			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	<p>deficient practice could affect all 37 residents in the facility.</p> <p>Findings include:</p> <p>Based on review of quarterly fire alarm system inspection reports in the Maintenance Bible First Edition on 08/21/12 at 10:30 a.m. with the Owner, Maintenance Supervisor and Administrator in Training (AIT) present, resident rooms were not provided with smoke detectors. Based on observations with the Owner, Maintenance Supervisor and AIT between 10:45 a.m. and 11:30 a.m., the resident rooms were not provided with smoke detectors. Based on interview during the time of observations, the Maintenance Supervisor acknowledged the resident rooms were not provided with smoke detectors.</p> <p>3.1-19(ff)</p>			<p>Potentially all residents could be effected. Please refer to systems implemented to assure compliance with this tag.</p> <p><b><i>The measures or systematic changes that have been put into place to ensure compliance with the environmental and physical standards.</i></b></p> <p>Smoke detectors have been purchased and installed in all residents' rooms. The review of the proper functioning of all smoke detectors and smoke detector batteries has been added to the preventive maintenance checklist so that it is reviewed on a routine basis.</p> <p><b><i>The corrective action taken to monitor performance to assure compliance through quality assurance is:</i></b></p> <p>The proper operation of the smoke detectors in all residents' rooms in correlation with the Environment and Physical Standards will be monitored as part of the preventive maintenance review at the quarterly QA meetings. The Maintenance Director, or designee, will be responsible for assuring that the smoke detectors and smoke detector batteries function properly. Any identified issues will be immediately addressed. The Administrator, or designee, will</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/01/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E376		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 08/21/2012	
NAME OF PROVIDER OR SUPPLIER  TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 305 E NORTH ST BOONVILLE, IN 47601			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
				<p>review the preventive maintenance documentation quarterly for compliance.</p> <p><b><i>The date the systemic changes were completed:</i></b></p> <p>August 28, 2012</p>			